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Month	Observance	Article
February	National Children's Dental Health Month www.ada.org	p 2
March	World Tuberculosis Day - March 24 www.who.int/gtb/index.htm	p 3
April	National STD Awareness Month http://www.ashastd.org/wad.html	p 4
May	Asthma & Allergy Awareness Month www.aafa.org	p 7
June	National HIV Testing Day www.napwa.org/hivtestinfo	p 9
July	Lead Poison Control Month **www.epa.gov/opptintr/lead**	p 10
August	National Immunization Awareness Month www.partnersforimmunization.org	p 11
September	Baby Safety Month www.jpma.org	p 12
October	Health Literacy Month www.healthliteracymonth.org	p 13
November	Great American Smokeout www.cancer.org	p 15
December	National Handwashing Awareness Week (Focus on Influenza Prevention by Immunization and proper hand hygiene.) www.henrythehand.com	p 17

Oral Health: Part of Total Health

By Peggy B. Yamagata, RDH, MEd.

Each year in February, the nation turns its focus to oral health in observance of Children's Dental Health Month. However, oral health issues do not begin or end in February. In June of 2000, U.S. Surgeon General David Satcher, MD, reminded us that "oral health means much more than healthy teeth." And in May of 2003, the surgeon general's office launched a "call to action," creating critical partnerships at all levels. The goals are to promote oral health, improve quality of life, and eliminate oral health disparities.

Dental health is not appreciated to the extent of physical health; despite recent research that dental disease has a widespread physical impact. Currently, it is the most common preventable infectious disease. Oral diseases are progressive and cumulative and can affect not only one's health, but also one's speech, appearance, and self-esteem. Studies have shown an association between dental health and growth. The growth of children was accelerated after having been previously stunted and reached the average height after treatment of dental disease (i). Children with dental diseases may have limited food choices. Without teeth or with tooth pain, it is difficult to chew healthy, crunchy foods such as some fruits and vegetables. Dental cavities are also aesthetically displeasing and may affect self-esteem and social behavior. Social development is a crucial aspect of overall child development, and dental disease may thereby have an impact on participation and success in school. As children become adults, there is a significant increase in the odds of heart disease among patients with periodontal disease (ii). Several studies also indicate a relationship between oral health and poor pregnancy outcomes (ii). Furthermore, more than 90% of all systemic diseases have oral manifestations (ii).

Most disconcerting is that 80% of untreated dental cavities are experienced by only 25% of children (ii). Additionally, substantial disparities in untreated cavity prevalence exist among racial/ethnic groups: 80% African-American, 71% Asian, 66% Latino/Hispanic, and 42% White (iii). Dental diseases are, however, preventable, and there are many things that a health professional can do in the clinical setting and beyond to curb this "epidemic."

Access to dental care is key but can be limited due to several factors, including lack of insurance and appropriate dental intervention. Nationally, for every child without medical insurance, there are 2.6 without dental insurance (ii). Physicians are often the only healthcare provider seen regularly. Given this fact, these providers have a great opportunity to prevent dental disease by:

- Providing an oral health risk assessment;
- Performing an oral screening exam as part of the routine physical exam;
- Evaluating fluoride intake and prescribing fluoride supplements and fluoride varnish;
- Providing appropriate referrals.

The American Academy of Pediatric Dentistry recommends a dental visit by the age of one. Children should receive preventive care from a dental provider at least once a year. High-risk populations should obtain preventive care twice each year. Physicians have the unique opportunity to encourage a dental visit during a well-baby or well-child exam. In addition, during routine well-child exams, the physician has an opportunity to promote oral health through anticipatory guidance. Guidance should include:

- Discussion about growth and development;
- Demonstration of a lift-the-lip exam;
- Encouragement of daily oral hygiene care;
- Discussion of age-related risks and protective factors, including mouth guards;
- Discussion of nutritional habits, including appropriate use of the bottle and sippy cups;
- Use of fluoride supplementation.

The County of San Diego is aggressively addressing this epidemic by conducting community awareness campaigns, educating various professional and community groups, providing no-cost sealant and fluoride varnish clinics for children with no resources for preventive care, and advocating for increased access to care.

For more information on dental health news, local activities, or to download patient education materials, visit the Share the Care/Dental Health Initiative website at www.sharethecaredental.org or call Peggy Yamagata, RDH, MEd, at 619/692.8858. ▮

Peggy B. Yamagata, RDH, MEd., is the program manager for the County of San Diego's Dental Health Initiative/Share the Care. In this position for the past 10 years, she has been responsible for program development and day-to-day activities of this oral health program.

Sources:

(i) Acs G. et al. Continuing Education in Dentistry. *1998: 19(2).*

(ii) USDHHS. Oral Health in America: A Report of the Surgeon General. *2000.*

(iii) Pollick J.F. et al. Report of the California Oral Health Needs Assessment of Children, 1993-94. *1999.*

TB in SD

By Kathleen Moser, MD, MPH

Globally, over eight million new cases of tuberculosis (TB) are diagnosed annually and at least two million die of this age-old disease. One-third of the global population has latent TB infection, of whom an estimated 10% will progress to active disease in their lifetimes. In the United States, after decades of historic decline, TB rates began to rise in 1985 due to a confluence of factors, including a rise in vulnerable populations, the emergence of HIV, and decades of inattention and underfunding of basic TB control efforts. In San Diego, case counts peaked in 1993 with 469 newly reported active cases. After a period of renewed investment and focus, TB is once again coming under control across the United States. In 2004, San Diego County reported 320 new cases, a 32% decrease from 1993. There should be caution, however, since the decline has leveled off in the past five years (299 cases in 1999). Despite our success, we have far to go in eliminating TB in our region.

San Diego County's TB rate of 10.7 cases per 100,000 population is similar to California's (8.9), but double the national rate of 5.1.

San Diego County's TB rate of 10.7 cases per 100,000 population is similar to California's (8.9), but double the national rate of 5.1. Part of this is linked to our County's position as a world crossroads. In 2003, 66% (209) of the county's TB cases occurred among the foreign-born; 104 (33%) were from Mexico, 87 (28%) were from Asia, and 9 (3%) from Africa. It is important for San Diego practitioners who care for immigrant and refugee populations to consider the diagnosis of TB whenever suggestive symptoms are present. Delays in diagnosis are fairly common, unfortunately, and 50% of pulmonary cases have positive sputum smears by the time TB is identified and often have seen providers multiple times before diagnosis.

Other populations should be kept in mind as at particular risk of TB. In 2003, 14% (43) of San Diego cases were among HIV-infected persons. Worldwide, tuberculosis is the leading cause of death in HIV-infected persons. While that is not the picture locally, TB disease complicates the treatment of HIV disease, and success in treating TB can be reduced in the HIV-infected patient. Thus, early detection of TB disease among HIV-infected patients is quite important, and, conversely, all adult patients diagnosed with active TB should be screened for HIV infection. Moreover, all HIV-infected individuals should be tested for latent TB infection (LTBI) as part of their initial evaluation and treated if LTBI is diagnosed.

Other groups at special risk of TB disease include patients on renal dialysis, individuals treated with Tumor Necrosis Factor-· antagonists, and post-transplant patients. These individuals should be screened early in their care, placed on TB preventive regimens if found to have latent infection, and vigilance maintained for the development of symptoms consistent with TB. Other groups with higher rates of LTBI and disease than the general population include homeless persons, alcoholics and substance abusers, inmate populations, and nursing home residents. Overall, it is estimated that 10% of the U.S. population is latently infected with TB. This translates to over 280,000 persons in San Diego County and, therefore, 28,000 potential future cases if left untreated. Practitioners have a central role in targeting such patients for TB testing and treatment. For more information, visit the Centers for Disease Control and Prevention (CDC) website for the 2000 Targeted Testing and Treatment of Latent TB Infection guidelines at

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Kathleen Moser, MD, MPH, is the director of the San Diego County TB and Refugee Health Program. She has held this position since 1989 and has been involved in healthcare and health policy issues, from local to international, that affect San Diego County residents.

San Diego County Health Stats:

TUBERCULOSIS

- San Diego County reported 316 cases of active TB in 2003. Persons born outside the United States comprised 66% (209 of 316) of the reported cases. The most frequent countries of birth were Mexico (104 cases), the Philippines (45 cases), and Viet Nam (16 cases).(i)
- Of the 316 cases reported in the county, TB drug susceptibility information was obtained on 242 (77%) of them. Resistance to at least one of the four major first-line drugs was found among 21% (52) of these specimens. Multi-drug resistant strains were found in 2% (5) of the cases. (i)

World Tuberculosis Day is March 24, 2005. For more information, go to the Stop TB Partnership at www.stoptb.org.

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends, and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

(i) County of San Diego Tuberculosis Control Program, 2003.

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www.cdc.gov, as well as for recent reports about groups at special risk for TB disease. Since the 1960s, the tuberculin skin test has been the recommended tool to screen individuals for TB infection. Most providers are well aware of the difficulties this test presents, including operator variability, need for a return office visit, and lack of specificity, especially among persons who have received the BCG vaccination. In 2001, the FDA approved QuantifERON (QFT), an in vitro test to diagnose TB infection. QFT is based on the quantification of interferon-gamma (IFN-) released from sensitized lymphocytes in whole blood incubated overnight with antigens from M. tuberculosis. The FDA named QFT, in their 2002 annual report, as one of the most significant new indications to impact patient care. In December 2004, a second generation QFT test was approved. QFT-TB GOLD uses antigens not found in BCG strains, and thus improves the specificity of the test in diagnosing LTBI.

As a diagnostic test, QFT can be accomplished after a single patient visit for phlebotomy and does not boost anamnestic immune responses. Medi-Cal approved QFT as a benefit starting February 1, 2005. The CDC will be releasing specific recommendations for its use later this year, but ideal populations for this test include healthcare workers and general screening for high-risk, asymptomatic populations such as the homeless, immigrants, and persons screened for workplace requirements. The test has been endorsed by the California and the National TB Controllers Associations.

Although new technology is exciting, it cannot replace old-fashioned surveillance and case management to ensure that all TB patients receive appropriate care and complete their treatment successfully. Healthcare providers are required to report all persons diagnosed or suspected to have active TB within 24 hours of suspicion. Seven-day-a-week reporting is available via the County of San Diego Health and Human Services Agency, TB Control Branch, at (619) 692-8610. Once reported, all patients will have a County public health nurse assist them with successful completion of treatment. As part of this service, patients receive their treatment via directly observed therapy (DOT). DOT involves a health worker observing ingestion of each dose of TB therapy and is recommended by the CDC and other authorities as the "… preferred core management strategy for all patients with tuberculosis."

The TB Control Branch provides DOT services for all patients in the county. For more information on the TB Control Branch visit, www.sandiegotbcontrol.org. Education plays a key role in the control of tuberculosis. With collaboration from the UCSD School of Medicine, the American Lung Association of San Diego and Imperial Counties, and the San Diego TB Control Branch, an annual "March on TB" conference has provided professional education since 1994. This year's day-long conference will take place on March 28, 2005. The goal is to update providers on the latest treatment guidelines, recent laboratory advances in diagnosis, and best practices for TB prevention. For a copy of the conference brochure, visit www.lungsandiego.org. ✖

Medical Leadership Council on Language Access Holds Sixth Meeting in Oakland

Members of the Medical Leadership Council on Language Access reported new collaborations and language access projects at their sixth meeting held November 8, 2004 in Oakland. Tom Gehring, SDCMS executive director, represented SDCMS at the meeting. Projects include a survey of local hospitals, best practice pilot projects, and physician office resource kits.

Presentation One:
Local Language Access Activities in Alameda County (Hospital Survey, New Coalition, Alameda Alliance for Health)

Presentation Two:
Continuing Medical Education on Language Access

Presentation Three:
Using Children as Interpreters

Presentation Four:
Endowment-funded Language Access Projects (St. Joseph Health System, California Latino Medical Association, American College of Obstetricians and Gynecologists, District IX, American College of Emergency Physicians, California Chapter, Catholic Healthcare West, California Safety Net Institute, California Association of Public Hospitals and Health Systems)

Presentation Five:
Legislative, Medical Board, and California Endowment Updates

The Council will continue its work for an additional two meetings in 2005. For more information about the presentations from the November 2004 meeting, contact Laura Johnson Morasch at lmorasch@family-docs.org. ✖

Lights! Camera! Action!

SDCMS needs physician experts to speak with local media on a wide range of healthcare topics.

You'll educate patients in our community, ensure proper media coverage of pressing medical issues, and defend patient and physician interests in a public forum. The only criteria: a passion for medicine and a willingness to be "on-call" for media opportunities. If interested, call Kyle Lewis at (858) 300-2784 or email him at klewis@sdcms.org. Please be ready to provide a short list of topics and issues in which you have expertise.

Sexually Transmitted Disease: **The Hidden Epidemic**

By Robert A. Gunn, MD, MPH

April is "STD Awareness Month," which is aptly titled because "awareness" is what is needed to address the epidemic of sexually transmitted disease (STD) that is occurring in the United States. In 1997, the Institute of Medicine (IOM) examined the nationwide status of STDs and released a major report, "The Hidden Epidemic: Confronting Sexually Transmitted Diseases" (i). The report indicated that approximately 12 million new cases of STDs are occurring annually in the United States, and the national incidence rates of curable STDs are the highest in the developed world. The authors concluded that "despite the tremendous health and economic burden of STDs, the scope and impact of the STD epidemic is … largely hidden from public discourse, and public awareness and knowledge regarding STDs are dangerously low."

One STD of particular concern in San Diego as well as in the entire country is genital tract Chlamydia trachomatis infection. This highly prevalent, easily curable bacterial STD is usually initially asymptomatic (more than 70%) among women, but it can lead to serious complications, such as pelvic inflammatory disease (PID), tubal scarring leading to ectopic pregnancy or infertility, chronic pelvic pain syndrome, and infections of the newborn — all causing considerable pain and suffering and medical care cost. In San Diego, chlamydia is the most common reportable disease, with more than 10,000 infections reported in 2003. Infection is most common among teens and young adults (less than 25 years of age) who account for two-thirds of all reported cases. Reported chlamydia cases have been increasing steadily from 5,250 cases in 1995 to currently more than 10,000 per year (90% increase) (ii). Increased screening using more sensitive tests probably accounts for much of this increase. Other data from ongoing prevalence monitoring show that chlamydia prevalence has declined slightly among 15–19 year-olds, suggesting that incidence may be declining or stable.

Diagnosis can be made using easily obtained urine specimens that are tested by nucleic acid amplification testing (NAAT). Specimens can be obtained during any preventive healthcare visit or any time a young sexually active person interacts with the medical care system. Since more females than males obtain preventive healthcare, many more females are tested, which explains the much higher population case rate among them compared to males (516 vs. 179 per 100,000).

The chlamydia problem is so important that the National Committee on Quality Assurance (NCQA), a recognized leader in assessing the quality of care provided by managed care organizations, added a chlamydia screening performance measure to its Health Plan and Employer Data Information Set (HEDIS). The measure calls for annual chlamydia screening of all sexually active women 15–25 years of age. The Centers for Disease Control and Prevention (CDC) also makes a similar recommendation and adds that screening should be done anytime a woman, especially a teen, has unprotected sex with a new partner. There are currently no screening recommendations for males; however, clinicians are encouraged to screen sexually active males in the same age group, especially those who have had multiple partners or a history of having STDs.

How can practicing physicians participate in this effort to increase the identification and treatment of this infection? First, taking a sexual risk assessment history on all new patients (and repeating annually) to determine the level of sexual risk-taking

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San Diego County Health Stats:

GENITAL CHLAMYDIA

- The number of reported genital chlamydia infections has increased more than 90% from 5,250 cases in 1995 to 10,249 in 2003, most likely due to increased screening with more sensitive tests (i).

- The estimated annual countywide chlamydia screening coverage of sexually active teenage girls (15–19 years old), based on observed and reported cases over expected, increased from 50% in 1998 to 88% in 2003 (ii).

April is National STD Awareness Month. For more information, go to the American Social Health Association's website at www.ashastd.org.

To request additional health statistics describing health behaviors, diseases and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

i. San Diego County STD Fact Sheet 2003 (1993–2003).
ii. Levine W.C., Dicker L.W., Devine O., Mosure D.J. "Indirect Estimation of Chlamydia Screening Coverage Using Public Health Surveillance Data," *American Journal of Epidemiology*, 2004; 160:91–96.

Robert A. Gunn, MD, MPH, STD Control Officer, was previously a member of the Division of STD Prevention, Centers for Disease Control and Prevention (CDC) and has worked with STD prevention activities in the Division of Public Health Services, Health and Human Services Agency, County of San Diego, since 1991. Dr. Gunn is also Adjunct Professor, Department of Family and Preventive Medicine, UCSD.

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behavior is very important. Young patients should be encouraged to practice safe sexual behavior such as abstinence, monogamy, and, when needed, correct condom use. For sexually active women less than 25 years of age, a urine screening test, using amplified technology (NAAT), is indicated. For those infected, a one-dose treatment with oral azithromycin 1.0 gm is highly efficacious and easily administered. Doxycycline100 mg. twice a day for seven days is equally efficacious and less expensive, but compliance can be problematic. For those treated, it is also important to prevent reinfections by having their sex partner(s) also treated, regardless of whether the partner is tested. California Law SB 648, effective January 2001, allows physicians to prescribe treatment for partners without establishing a professional relationship with them. The patient can deliver the prescription or medication.

How are San Diego clinicians doing in carrying out this chlamydia screening recommendation? Using a CDC screening coverage estimation method, in 1998 the number of chlamydia cases reported among teenage girls comprised only 50% of the estimated total chlamydia burden among this age group, whereas in 2003, 88% of the estimated total chlamydia was diagnosed and reported. Although these data suggest an impressive increase in effective screening in San Diego, direct reports from managed care plans show statewide that the HEDIS chlamydia screening measure coverage rate is less than 40% in most plans, clearly room for improvement.

The tools are available for clinicians to easily identify and treat chlamydia and prevent many of the very consequential complications among women and infants. We encourage clinicians to review the excellent website at the American Social Health Association (www.ashastd.org) or contact the County STD Program directly to obtain any needed information. We also distribute a brief STD update via email five to eight times per year to alert clinicians about developments in STD epidemiology, diagnosis, and treatment. We would like to add interested physicians to our email distribution list (currently 650 subscribers). To add your name, email stdhep.hhsa@sdcounty.ca.gov and type "subscribe" in the subject line or contact Craig Sturak at (619) 692-8369. For those physicians not actively using email, the update can be faxed. Consultation on any STD issue is available at (619) 692-8082 with Robert A. Gunn, MD, MPH (STD control officer) or Robert A. Gilchick, MD, MPH (STD clinical services director). Reports of STDs by Confidential Morbidity Report (CMR) can be faxed to (619) 692-8541 or by calling (619) 692-8501 for assistance.

(i) Eng R.T., Butler W.T. The Hidden Epidemic: Confronting Sexually Transmitted Diseases. *National Academy Press, Washington, DC, 1997. Summary available www.nap.edu.*

(ii) STD Fact Sheet. STDs by year of report 1994–2003. STD, Program, HIV, STD, and Hepatitis Prevention Branch, Public Health Services, HHSA, San Diego County.

The San Diego Pediatric Asthma Provider Education Initiative

By Amethyst C. Cureg, MD

Asthma affects not only the health and daily life of children with asthma but also their families, friends, schools, businesses and taxpayers. The prevalence of asthma over the past decade has been rising and is one of the leading causes of chronic diseases and hospitalizations in San Diego. According to the 2001 California Health Interview Survey, 14.7 percent of San Diego County children (ages 1–17) have been diagnosed with asthma compared to 10.8 percent of adults (i). At 14.7 percent, San Diego County has the second-highest childhood asthma prevalence rates in southern California, exceeding the state average of 13.6 percent (ii). Statistics also show disproportionate rates of asthma symptoms and hospitalization and emergency room use, based on income, race and ethnicity.

Asthma is one of the chronic diseases that define a pediatric practice. Many challenges are faced in asthma's diagnosis and management. Undoubtedly, medicine has come a long way with asthma management, since residency training in the 1970s, when theophylline was the drug of choice for home therapy and every child admitted received intravenous aminophylline and steroids. Now, more is known about the molecular basis of asthma, exposures can be assessed, and a wide array of available therapies can be chosen with molecular pathophysiology in mind. To help bridge the gap between current knowledge and practice, in 1997, the National Heart, Lung, and Blood Institute (NLHBI) released guidelines for the diagnosis and treatment of asthma to improve the quality of care for children with asthma.

Physicians play a key role in implementing evidence-based recommendations to improve outcomes, but compliance is generally low. A recent quality improvement study, conducted in San Diego, showed that only 30 percent of patients had documented disease severity; steroids were generally under-prescribed; many patients received inadequate education; few patients were asked to demonstrate proper inhaler use technique; and not many patients utilized disease monitoring devices such as peak flow meters. Moreover, no written asthma treatment plans were found in charts of children with asthma. There are barriers to the implementation and adherence of these guidelines. Focus groups suggested that physicians face varying barriers to the implementation of the guidelines such as a lack of familiarity or agreement with the NLHBI guidelines, economic disincentives, patient

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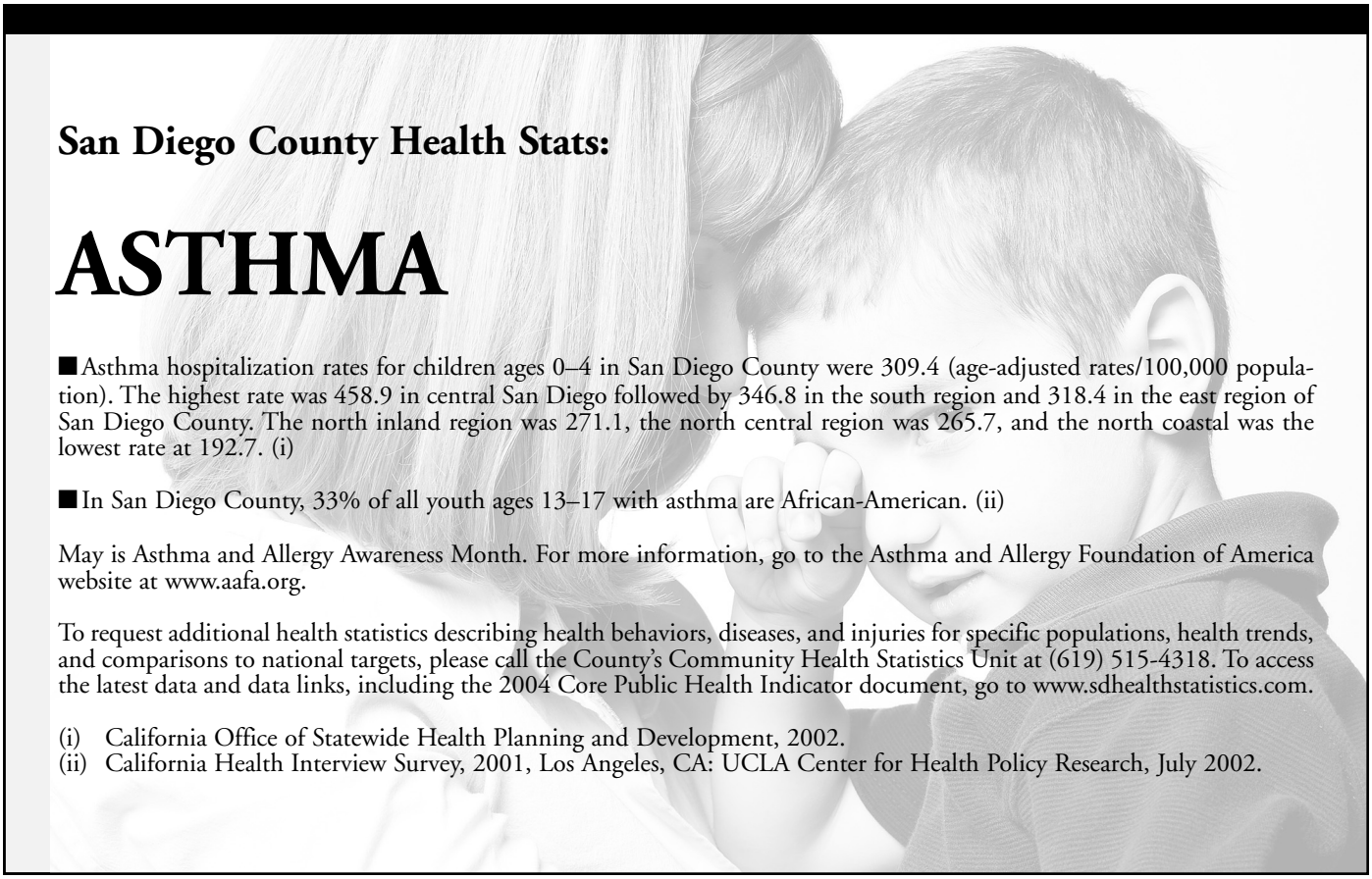

San Diego County Health Stats:

ASTHMA

■ Asthma hospitalization rates for children ages 0–4 in San Diego County were 309.4 (age-adjusted rates/100,000 population). The highest rate was 458.9 in central San Diego followed by 346.8 in the south region and 318.4 in the east region of San Diego County. The north inland region was 271.1, the north central region was 265.7, and the north coastal was the lowest rate at 192.7. (i)

■ In San Diego County, 33% of all youth ages 13–17 with asthma are African-American. (ii)

May is Asthma and Allergy Awareness Month. For more information, go to the Asthma and Allergy Foundation of America website at www.aafa.org.

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends, and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

(i) California Office of Statewide Health Planning and Development, 2002.
(ii) California Health Interview Survey, 2001, Los Angeles, CA: UCLA Center for Health Policy Research, July 2002.

Dr. Cureg is the County of San Diego Health and Human Services Agency maternal and child health medical director and director of the Child Health and Disability Prevention Program. She is a past vice president of the American Academy of Pediatrics (AAP), Chapter 3, District 9, and serves on the AAP Advisory Board.

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non-compliance, and inadequate time or resources (iii).

To overcome barriers to implementation of the guidelines, the County of San Diego Health and Human Services Agency, in partnership with the American Academy of Pediatrics (AAP), implemented the San Diego Pediatric Provider Education Asthma Initiative (SDPAPEI). This initiative has provided specific changes at the individual physician practice level — through targeted physician education — that positively impact the health of children with asthma in San Diego. SDPAPEI implemented a modified Institute for Healthcare Improvement (IHI) breakthrough quality improvement series, adapted for the medical setting, to introduce physicians to goal setting, self-evaluation, chart review, and other essential elements of the physician practice change model.

SDPAPEI sought to reduce the gaps in asthma care through the implementation of the NHLBI guidelines for asthma. SDPAPEI focused on key factors known to improve asthma management: 1) the use of correct classification of asthma severity; 2) appropriate use of controller medications; 3) proper techniques for medication delivery and disease monitoring devices; 4) written Asthma Action Plan; and 5) education of individuals who provide care or supervise the child. SDPAPEI targeted medical practices that served areas where children have high rates of asthma hospitalizations and emergency room use.

Results showed that 73 percent of responding SDPAPEI participants stated that, to a great extent, the program helped them classify asthma severity in their practice; 59 percent noticed a decrease in asthma exacerbations, sick visits, or ER visits in their patients. Responses to the survey conducted to determine physician behavior change were positive, as 100 percent of respondents stated that participation in the program changed the way they treat children with asthma. Our experience shows that targeted physician education is effective in changing physician behavior and is an alternative to the traditional learning approach.

Physicians interested in learning or implementing asthma SDPAPEI tools should contact Dr. Cureg at (619) 692-8808, Dr. Pradeep Gidwani at (858) 576-1700, ext. 4133, or Matt Wimmer at (858) 576-1700, ext. 4478. Resources, including the San Diego Asthma Report Card and many of the SDPAPEI tools are also available at www.lungsandiego.org and www.sdrac.org. ■

References:

(i) California Health Interview Survey, 2001, Los Angeles, CA: UCLA Center for Health Policy Research, July 2002.
(ii) San Diego Asthma Regional Asthma Coalition. Asthma Report Card 2004
(iii) Unpublished report.

HIV Disease

IN SAN DIEGO COUNTY

By Terry Cunningham

Upon the enactment of the Ryan White CARE Act in August of 1990, San Diego County already had reported in excess of 2,000 cases of AIDS. At that time, the life expectancy of affected individuals averaged less than a year. Many factors in the HIV/AIDS disease epidemic have changed over the past three decades. The disease itself has changed dramatically from a death sentence to a virtually controllable, chronic illness. The advent of HAART (Highly Active Antiretroviral Therapy) in 1996 contributed to this change in life expectancy of infected individuals. Since this innovation, the lives of the vast majority of people diagnosed with HIV have not only been extended but also improved. Many have been diagnosed early with HIV and have not progressed to AIDS because of HAART therapy. However, there is still a significant number of individuals who cannot tolerate the medications that comprise the treatment regimen. With more people living with HIV and fewer progressing to AIDS, the reporting of HIV has become more important in determining the new directions of the disease.

By the end of March 2005, a cumulative total of 12,230 people have been diagnosed with AIDS in San Diego County. Since the beginning of HIV reporting, in July of 2002, over 4,693 individuals have been diagnosed with HIV disease. Locally, by comparison to Caucasians, African Americans and Native Americans are over-represented disproportionately in the AIDS epidemic. Caucasians experience the greatest number of HIV/AIDS cases; however, projections predict a continuing gradual decline in Caucasian cases, with increases in both Hispanic and African-Americans cases. According to San Diego Association of Governments' (SANDAG) current estimates for 2004, the racial/ethnic breakdown for the county population is 52.1 percent white, 28.4 percent Hispanic, 9.9 percent Asian, 5.3 percent black and 3.1 percent for two or more other races. Provision of services in a county with this degree of ethnic diversity includes the need for culturally and linguistically appropriate services in all areas, the ability to attract traditionally disenfranchised populations into the planning process for services, and the capacity to provide continuity of services to a transient population. Additionally, the provision of services to confront this epidemic is exacerbated by the more than 40 million border crossings per year between Tijuana and San Diego.

The largest concentration of individuals diagnosed with AIDS is in central San Diego, with the South Bay and southeast San Diego area having the second largest numbers. HIV/AIDS services are correspondingly placed in the areas most severely affected. Fortunately, the primary care safety net system of community clinics has been responsive to the HIV/AIDS disease epidemic. All areas of the county have at least one community clinic with Ryan White CARE Act funding for primary medical care. The familiarity of each clinic with its surrounding community helps to foster client trust and to ensure the delivery of culturally appropriate services to each unique region.

One of the most important services provided by the county and community medical partners to promote prevention is counseling and testing. The county's HIV Counseling and Testing Unit provides over 13,000 HIV tests a year in all regions of the county. The new Rapid Test, or OraSure, now facilitates the increasing demand for HIV testing. Just two years ago, the Rapid Test for HIV was piloted, through the state, in San Diego and is now a standard part of the menu of available testing options. This test now requires only a small sample of cells taken painlessly from the inside of the cheek. Test results are available in approximately 30 minutes. Both anonymous and confidential testing is provided. Testing is done at fixed sites and also at the Mobile Testing Unit, which travels throughout San Diego County. For more information on the availability of HIV testing, please call (619) 296-2120.

While the future for individuals affected by HIV infection or AIDS is brighter than in previous times, the future of supportive services to that same population is uncertain. Despite the increasing numbers of AIDS and HIV cases, funding is declining. Federal and state budgets have been severely impacted by a variety of external influences. Over the past few years, HIV prevention funding has been cut from $3 million to $1.7 million. Likewise, in the past two years, funding for Ryan White CARE Act care and treatment services has received over a $1 million cut.

The HIV, STD and Hepatitis Branch (formerly the two separate branches of the Office of AIDS and STD Control/Hepatitis) of Public Health Services includes the following HIV and AIDS services: HIV Prevention, AIDS Case Management, Intensive Case Management, HIV Counseling and Testing, AIDS Drug Assistance Program, Contract Monitoring, and Contract Administration. For additional information, the general phone number of the branch is (619) 296-3400. Through contracts with community partners, the county is able to provide a wide range of services to individuals whose lives have been affected by this disease.

Please note that June 27 is National HIV Testing Day (NHTD). This observance is an annual campaign, produced by the National Association of People with AIDS (NAPWA-US), to encourage at-risk individuals to receive voluntary HIV counseling and testing. Physicians are important leaders and play a unique role in the process to promote HIV prevention through HIV counseling and testing. During the month of June, and every opportunity that is appropriate, local physicians are asked to encourage patients to get tested for HIV. ❑

San Diego County Health Stats: HIV

- ✔ For the last three years, (2002–2004, with the 2004 data still preliminary), women testing at the Anonymous HIV Counseling and Testing Services had a 0.8% HIV infection rate. The age group with the highest rate was women 35 and up with a rate of 1.0%. The rate for women 20–34 was 0.7%. (i)
- ✔ Until 1999, more than 50% of all AIDS cases by racial/ethnic group were white. Since 2000, more than 50% of cases per year have been reported among persons of color (African Americans, Asians, Pacific Islanders, Hispanics and native Americans). (ii)

June is National HIV Testing Month. For more information, go to the National Association of People With AIDS website at www.napwa.org/hivtestinfo. To request additional health statistics describing health behaviors, diseases and injuries for specific populations, health trends and comparisons to national targets, please call San Diego County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

i. County of San Diego HIV Counseling and Testing Data. State of California, Department of Health Services, Office of AIDS, 2004.
ii. County of San Diego HIV/AIDS Epidemiology, 2004.

About the Author: *Terry Cunningham, who has a master of arts in organization management, has been the chief for the Office of AIDS Coordination for nearly seven years and is now chief of the newly formed HIV, STD and Hepatitis Branch of Public Health Services. For the past 23 years, he has worked locally in the area of HIV/AIDS in a variety of capacities.*

Childhood Lead Poisoning

By Tina R. Muñoz

Lead poisoning remains a significant problem for children in the United States. According to a report in the Morbidity and Mortality Weekly Report (MMWR), approximately 310,000 children in the United States remain at risk for lead exposure.[1] Last year in San Diego County, the Childhood Lead Poisoning Prevention Program (CLPPP) reported 53 cases (> 15 µg/dL) and 77 early prevention cases (> 10 µg/dL) for a combined total of 130 lead poisoned children.[2]

Although rates of childhood lead poisoning have decreased over the years due to removal of lead from paint and gasoline, the remnants of this metal can be found in old housing stock and contaminated soil. 70 percent of San Diego County homes were built before 1978 (the year lead was removed from paint). Additionally, other sources have been identified that contribute to lead poisoning. Home remedies, pottery/decorative dishware, candies made with tamarind and/or chili, children's toys and/or costume jewelry have accounted for approximately 74 percent of lead poisoning cases in San Diego County children.[3]

The Centers for Disease Control and Prevention (CDC) previously set the level of concern for lead poisoning at 10 µg per deciliter of blood. Lower blood lead concentrations are now linked to intellectual impairment. A study in the *New England Journal of Medicine* reported a decrease in IQ of 7.4 points in children with blood lead levels between 1 and 10 µg per deciliter.[4] Preliminary results from CLPPP data in 2005 identified approximately 300 children between the months of January and March with lead levels between 1 and 10 µg per deciliter. Children are subject to learning disabilities when small amounts of lead are Ingested/inhaled.

Testing children for elevated blood lead levels is the only way to diagnose lead poisoning. Typically symptoms are non-specific, such as stomach pain, irritability and poor appetite. In the May 2005 issue of *JAMA*, two articles discussed the screening and retesting of children with elevated lead levels. Findings revealed 46 percent of children did not receive the required follow-up testing. In addition 58.6 percent of these children had a minimum of 1 doctor visit in the months following the lead screening test.[5, 6]

Physicians hold the key to assisting CLPPP and local housing enforcement agencies in the prevention of this environmental hazard in children. Screening at-risk children and requiring follow-up testing for children with elevated lead levels will help these children to receive proper case management services which includes extensive home interview, health education, environmental testing of paint, dust and soil and referral for remediation if applicable.

The County of San Diego's Childhood Lead Poisoning Prevention Program offers assistance to physicians. In-services for physicians and office staff will provide knowledge of reporting and testing guidelines, sources of exposure, San Diego County case data, prevention methods, educational resources, case management services for children with blood lead levels of >15 µg per deciliter, and early prevention program services for children with blood lead levels of 9.5–14.5 µg per deciliter. Fingerstick training by a public health nurse is also available. Healthcare provider offices that have staff trained to conduct fingerstick testing can easily test children during well-child visits.

Physicians interested in these in-services and fingerstick trainings may contact the Childhood Lead Poisoning Prevention Program (CLPPP) at (619) 515-6694.

References:
1. Schwemberger JG, et al. Blood Lead Levels — United States, 1999–2002. Morbidity and Mortality Weekly Report 54 (20): 513-516, May 2005.
2. San Diego County statistics.
3. San Diego County statistics.
4. Canfield R., et al. Intellectual Impairment in Children with Blood Lead Concentrations Below 10 µg per Deciliter. The New England Journal of Medicine. 348 (16): 1517–1526, April 2003.
5. Lanphear B Childhood. Lead Poisoning Prevention Too Little, Too Late. JAMA. 293 (18) 2274-2276, May 2005.
6. Kemper A., et al. Follow-up Testing Among Children With Elevated Screening Blood Lead Levels. JAMA. 293 (18) 2232-2237, May 2005.

San Diego County Health Stats: CHILDHOOD LEAD POISONING

■ San Diego County identified 53 cases of childhood lead poisoning in 2004. Of these, 54.7 percent or 29 cases were identified in children between the ages of one and two. There were 46 cases for which race/ethnicity was identified, of these 39 or 84.8 percent were Hispanic.[1]

■ Childhood lead poisoning cases were identified throughout San Diego County. Following is the number of cases identified by region within San Diego in 2004: North Coastal had 12 cases, North Central had 2 cases, Central had 25 cases, South had 7 cases, East had 4 cases, and North Inland had 3 cases.[1]

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

1. County of San Diego Childhood Lead Poison Prevention Program, 2005.

About the Author: *Tina R. Muñoz is a health information specialist with the County of San Diego Health and Human Services Agency's Childhood Lead Poisoning Prevention Program.*

Immunizations:

A CELEBRATION OF SUCCESS AND A CHALLENGE FOR THE FUTURE

By Harrison Bolter

August is National Immunization Awareness Month, and the San Diego County Immunization Initiative, a coalition of more than 150 public and private health-related organizations, is asking people throughout the region to check if they and their loved ones are up-to-date on their immunizations. August is a particularly good time to focus community attention on the value of immunization. Parents are enrolling children in school, older students are entering college, and seniors and the healthcare community are preparing for the upcoming influenza season.

National Immunization Awareness Month is also an opportunity to celebrate immunization as one of the great public health success stories of the 20th century (1). As a proven and cost-effective method to protect the public's health, vaccines provide protection both to individuals and to the community as well by preventing the transmission of infectious diseases to persons who cannot be, or are not, immunized. "Before vaccines protecting against diseases such as measles, polio, and pertussis became available, those diseases caused tens of thousands of deaths each year in the U.S.," said Nancy Bowen, MD, health officer for San Diego County. "Because today's vaccines are recognized as safe and effective, members of our community can and should be protected by being up to date on their immunizations."

At the same time, the celebration should not obscure the fact that more work needs to be done. Americans can be proud that the United States experiences relatively few cases of many of the vaccine-preventable diseases, like measles, polio, and rubella. But the occurrence of cases of other vaccine-preventable diseases is illustrating the gaps in vaccination coverage in locations throughout the country.

Pertussis, for example, is often spread by unprotected parents or siblings to infants too young to be fully immunized. This year in San Diego County, 124 pertussis cases have been reported as of late June, as compared to 49 cases reported for the same period last year. Of these, 35 (28%) were less than one year of age, 24 (19%) were children ages 1–9, 34 (27%) were children or adolescents ages 10–19, and 31 (25%) were adults over 20 years of age (2). With regards to pertussis immunization in particular, there is good news. There had been no pertussis-containing vaccine approved for use in children 7 years of age or older. Because the effectiveness of the pertussis immunization received as an infant begins to wane after 5–6 years, an approved vaccine for older children and adolescents is needed.

To address this issue, earlier this year, GlaxoSmithKline and Sanofi-Pasteur's Tdap (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed) vaccines, for use with 10–18 year olds and 11–64 year olds, respectively, received approval from the U.S. Food and Drug Administration. Official recommendations for use of Tdap were issued after the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) meeting in late June 2005.

It is important to remind patients and families that vaccine-preventable diseases have not gone away but still threaten the community. The resurgence of polio in Nigeria and the spread of this disease to Yemen and Indonesia serve as powerful reminders that it is critical to maintain high immunization rates in San Diego County so that diseases once thought to be under control don't reappear in the community to cause more illness and suffering. Each year, the nation spends billions of dollars treating people for vaccine-preventable diseases, and each year, on average, more than 47,000 people die from these diseases. It makes so much more sense to prevent diseases rather than have to deal with the diseases themselves and the suffering they cause.

Healthcare providers play a pivotal role in helping their patients keep their immunizations current. Patients look to providers for advice and guidance on health issues. Of course, there are many demands on providers' time, but it is very important for them to take advantage of every opportunity to discuss the importance of immunization with patients. Those patients may have questions that only their providers can answer.

The CDC and the County of San Diego Health and Human Services Agency's Immunization Branch currently recommend that children receive vaccines against thirteen infectious diseases, including diphtheria, tetanus, pertussis, measles, mumps, rubella, chickenpox, polio, and others. Adolescents should be vaccinated against tetanus, diphtheria, and meningococcal disease, and others that may have been missed earlier, like hepatitis A and hepatitis B. Immunizations recommended for adults include vaccines against influenza, pneumococcal disease, tetanus, and diphtheria.

For more information about vaccines, vaccine-preventable diseases, and a wealth of helpful materials, please contact the San Diego County Immunization Initiative at (619) 692-8661, or visit www.immunization-sd.org and go to the Health Care Providers section. More information about National Immunization Awareness Month is available at the Partners for Immunizations website at www.partnersforimmunization.org.

1. *Morbidity and Mortality Weekly Report; April 02, 1999; 48(12): 241-243.*
2. *Immunization Branch, County of San Diego Health and Human Services Agency, 2005.*

About the Author: *Harrison Bolter is the health information specialist for the County of San Diego Health and Human Services Agency's Immunization Branch. He has held this position for the past nine years and is involved in the production of educational materials, in both printed and electronic form, for the Branch.*

San Diego County Health Stats: REPORTED DISEASES

■ In 2004, 116 cases of pertussis were reported in San Diego County. This had been the highest yearly total since 2002, when 230 cases were reported (1).

■ In contrast, no cases of polio, measles, diphtheria, tetanus, or Haemophilus influenza type b were reported in the County in 2004 (2).

1. Immunization Branch, County of San Diego Health and Human Services Agency, 2005.
2. Ibid.

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

Are There Guns Where the Children Play?

PHYSICIANS CAN AND SHOULD MAKE AN IMPACT

By Amethyst C. Cureg, MD

On Christmas Eve, Marie Cromwell's son Brian walked across the street to his friend Matt's house to play. He never came home again. Matt's mother kept an unlocked, loaded gun in her dresser drawer for protection. Matt pulled it out, and the gun went off. Brian died on the operating table; he was only 12 years old.

Sadly, this story plays out in many communities across the nation today. Citizens buy guns for protection, but it is rarely used for this purpose. Forty percent of homes with children have guns, many of which are left unlocked or loaded. A 1992 study showed that people used guns in self-defense in less than 1 percent of all violent crimes (1). A five-year study from the National Crime Victimization Survey found guns kept in the home for protection are much more likely to result in the death of a friend, family member, or neighbor (2).

Gun-related death in the United States is eight times higher than in other developed countries around the world, and children under 15 in this country die of gunshot wounds at a rate 12 times greater than that of children from 25 other industrialized countries (3). In 1997, firearm-related deaths accounted for 22.5 percent of all injury deaths in children and adolescents 1 through 19 years of age. Twenty-four percent of firearm-related deaths in children younger than five years of age are attributable to unintentional shootings, 26 percent for children 5 through 9 years of age, 21 percent for children 10 through 14 years of age, and 5 percent for adolescents 15 through 19 years of age. Most unintentional shootings occur among children left unsupervised at home (4).

Parents want their children to be safe and must provide a protected environment, including car seats, seatbelts, bike helmets, shin guards, etc. Some parents falsely assume that educating children about gun safety will confer safety. For developmental reasons, educational interventions are unlikely to be effective for many children and adolescents (5). Nearly two thirds of parents, of school aged children, with firearms in the home believe that the gun is stored safely. A study among 8–12-year-old boys showed that 72 percent of boys found guns that were hidden, 48 percent pulled the trigger, and half of the boys who found the gun thought it was a toy. More than 70 percent of the boys who handled the gun or pulled the trigger had previously received some sort of gun safety instruction (6).

Physicians see, treat, and struggle with families faced with the gruesome consequences of gun injuries: death, disability, pain, and suffering. Yet, as a medical community, providers often fail to address this public-health problem in the same manner as any infectious epidemic that would plague our children. Physicians provide relatively little firearm-safety counseling, according to the American Academy of Pediatrics (AAP) survey of 1,060 U.S. physicians. Only 12 percent of pediatricians surveyed stated that they always identify families who have firearms in their homes, and 33 percent reported they always recommend that families unload and lock away their guns (7).

Physicians can and should make an impact! There are three parts to patient education. First, ask families about the presence of guns in the home, and talk about the benefits of removing these weapons and the risks of gun injury. The most effective measure to prevent firearm-related injuries to children is the absence of guns from homes and communities. If guns cannot be removed from the home, countermeasures can be implemented. Actions include restriction of access by storing the arms properly, with the guns and ammunition stored and locked separately and away from children. California State law holds gun owners responsible if they leave a gun easily accessible to a child under 18 years old and the child uses the gun to injure or threaten someone or the gun is taken to school (8). California State law also requires every gun to be sold with a state-approved firearm-safety device that is identified as appropriate for that firearm (9, 10).

Patient education should include simple messages in a non-judgmental, sensitive way: 1) To keep a gun in the home poses a real danger to your family; 2) The safest thing is not to have a gun in your home, especially handguns; and 3) If you keep a gun, empty it, use a firearm-safety device (trigger lock), lock it separately from ammunition, and hide the keys where your children will not find either.

Secondly, it is important to tell parents to be aware of gun risks that their children may face in the homes they visit. Physicians must encourage parents to ask about guns before sending them to someone else's home. If the answer is yes, parents should be completely sure that all guns are unloaded, equipped with a firearm-safety lock, locked preferably in a gun safe with ammunitions locked separately. Hiding guns is not enough. Children are naturally curious, and if a gun is accessible in home, they will most likely find it and play with it (6). If parents have any doubt about the safety of the homes their children visit, parents should invite the children to their home instead.

Thirdly, teach children that if they come across a gun to: Stop, Don't Touch, Remove Yourself From the Area, and Tell an Adult.

September is Baby Safety Month. Additional resources about firearm safety such as patient education brochures, facts, and office posters are available by visiting the following sites: www.aap.org/moc/srr/firearmkit/resources.htm, www.safekids.com, www.waceasefire.org/ask www.cphv.org. ●

About the Author: *Dr. Cureg is the County of San Diego Health and Human Services Agency maternal and child health medical director and director of the Child Health and Disability Prevention Program. She is past vice president of the American Academy of Pediatrics (AAP), Chapter 3, District 9, and serves on the AAP advisory board.*

References:

1. *McDowall D, Loftin C, Wiersema B: The incidence of civilian defensive firearm use. College Park, Md: Violence Research Group, Institute of Criminal Justice and Criminology, University of Maryland, 1992.*
2. *Uniform crime reports Washington, DC, U.S. Dept. of Justice. 1996.*
3. *Krug EG, Powell KE, Dahlberg LL: Firearm-related deaths in the United States and 35 other high and upper-middle-income countries.* Intl. Journal of Epidemiology. *1998;27:214–221.*
4. *American Academy of Pediatrics Committee of Injury and Poison Prevention: Firearm-related injuries affecting the pediatric population.* Pediatrics. *2000;4:888-895.*
5. *Colyer E. et al.: Can conflict resolution increase aggressive behavior in young adolescents?* American Journal of Public Health. *1996;86:1028-1029.*
6. *Jackman GA, Farah MM, et al.: Seeing is believing: What do boys do when they find real a real gun?* Pediatrics. *2001;107:1247–1250.*
7. *Survey results available at: www.aap.org/research/periodicsurveys/ps25.htm, accessed July 19, 2005.*
8. *Information about California Penal Code 12071 "Dangerous Weapons Control Law" available at: http://ag.ca.gov/firearms/dwcl/12070.htm, accessed July 20, 2005.*
9. *Information about California Penal Code 12088.1 "Dangerous Weapons Control Law" available at: http://ag.ca.gov/firearms/dwcl/dwc.htm, accessed July 20, 2005.*
10. *Information regarding CA gun laws available at: www.bradycampaign.org/legislation/state/viewstate.php?st=ca, accessed July 20, 2005.*

SAN DIEGO COUNTY HEALTH STATS:
FIREARM INCIDENTS

- In San Diego County from 1999 through 2001, there were 38 cases of non-fatal, pre-hospital patients injured by firearms between the ages of 0 and 14 (1).
- In San Diego County from 1995 through 2004, 19 children between the ages of 0 and 14 were killed by firearm-related incidents (2).

September is Baby Safety Month. Information on firearm safety in the home is one of several measures to protect infants. For more information about firearm safety specifically, go to the American Academy of Pediatrics website at www.aap.org. For more information about general product safety for infants in the home, go to the Juvenile Products Manufacturers Association website at www.jpma.org.

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

1. *County of San Diego Emergency Medical Services, Pre-hospital Database, 1999–2001.*
2. *County of San Diego, Emergency Medical Services, Medical Examiner Database, 1995–2004.*

Low Health Literacy:

THE HUMAN AND FINANCIAL COSTS

By Kimberly C. Pettiford, MPH

In the past few years, a national movement to address health literacy has developed. The issue is a significant problem for both patients and healthcare providers; it may also be a factor contributing to health disparities. The medical community must play a key role in mounting strategies to ensure that patients receive assistance in overcoming barriers that limit their ability to function adequately in managing their medical care.

Literacy affects every area in an individual's personal and private life, including education, employment, social relationships, and health. In fact, literacy skills are a stronger predictor of health status than a range of other categories, including race/ethnicity, income, age, employment status, and educational level (1). Most individuals with limited general literacy also have limited health literacy. By definition, health literacy is the ability to read, understand, and use health information to make appropriate healthcare decisions and follow instructions for treatment (2). The American Medical Association Council on Scientific Affairs specifically defines functional health literacy as "the ability to read and comprehend prescription bottles, appointment slips, and other essential health-related materials required to successfully function as a patient" (3). Inadequate health literacy affects all segments of the population. However, it is more common in certain demographic groups, such as the elderly, the poor, members of minority groups, and recent immigrants to the United States (4).

Exchange of health information in an understandable manner is essential for the delivery of effective healthcare. This level of communication is specifically important in interactions between providers and low health literacy patients.

Because medical care has grown increasingly complex, the need for patients to be health literate is greater than ever. Patients are treated with an ever-increasing array of medications and asked to adhere to more and more complicated self-care regimens. Therefore, communication between a patient and their provider is essential to their health and well-being. Unfortunately, there is often incompatibility between a clinician's level of communication and a patient's level of comprehension. In fact, the Institute of Medicine reports that almost half of American adults (90 million people) have difficulty understanding and using health information (5). A patient's inability to understand health information can lead to medication errors, missed appointments, adverse medical outcomes, and even malpractice (2).

Inadequate or low health literacy has both human and financial costs. A recent study by Research Triangle Institute (RTI) International, the University of North Carolina's Evidence-based Practice Center, revealed that patients with low literacy had lower health knowledge, less utilization of health resources, and poorer health outcomes, including intermediate disease markers, measures of morbidity, and general health status (6). Patients with low health literacy were 1.5 to 3 times more likely to experience a poor health outcome than patients with higher health literacy. Also, low health literacy is significantly associated with an increased risk of hospitalization. Moreover, patients who struggle with low health literacy are: 1) often less likely to comply with prescribed treatment and self-care regimens, 2) fail to seek preventative care and are at higher (more than double) risk for hospitalization, and 3) remain in the hospital nearly two days longer than adults with higher health literacy. In regards to medical costs, people with low health literacy incur medical expenses that are up to four times greater than patients with adequate literacy skills. These costs are often associated with increased emergency department visits, doctor visits, prescribed medications, and longer hospital stays. As much as $58 billion each year is spent on unnecessary doctor visits and hospital stays due to low health literacy (1).

There is a strong possibility that some of your patients are among the 90 million people in the United States whose health may be at risk due to difficulty in understanding and acting on the health information received. You may not have identified these patients because some patients: 1) hide their confusion from their doctors because they are often embarrassed or ashamed to admit that they are having difficulty understanding health information or instructions, 2) use well-practiced coping mechanisms that effectively mask their problem, and/or 3) may be too intimated to ask for help. Examples of patient coping mechanisms include taking medical forms home to complete them, saying that they can't read it now because they've forgotten their glasses, handing written materials to a relative or someone else accompanying them, and/or aloofness or withdrawal during physician/provider explanations.

Physicians and medical organizations can improve the treatment of their low health literacy patients by using tools specifically designed for such patients to overcome barriers that may limit their ability to function in the healthcare environment. The AMA Foundation has developed a health literacy education kit specifically for clinicians. The learning objectives of the kit are to understand the full scope of health literacy, recognize health system barriers faced by patients with low health literacy, improve verbal and written communication to patients, and create a "shame-free" environment for patients. The kit can also be used to obtain contin-

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Six Easy Steps To Enhance Patient Understanding

1. Slow down and take the time to assess your patients' health literacy skills with available tool kits.

2. Use "living-room" language instead of medical terminology. Instead of saying, "the cancer has metastasized," say that "the cancer has spread."

3. Show or draw pictures to enhance patients' comprehension and recall of the information at a later time.

4. Repeat information and don't overwhelm patients with too much information.

5. Ask patients to repeat information back to you; this tactic is known as "teach back" and helps providers determine if patients understood what they were told.

6. Throughout this process, demonstrate respect and sensitivity towards patients, which empowers them to participate in their own healthcare.

uing education credit and can be purchased through AMA Press by calling (800) 621-8335. For more information visit the AMA Foundation website at www.ama-assn.org.

There are six easy steps that providers may employ to enhance understanding among patients with low health literacy (7). First, slow down and take the time to assess your patients' health literacy skills with available tool kits. Second, use "living-room" language instead of medical terminology. Instead of saying, "the cancer has metastasized," say that "the cancer has spread." Third, show or draw pictures to enhance patients' comprehension and recall of the information at a later time. Fourth, repeat information and don't overwhelm patients with too much information. Fifth, ask patients to repeat information back to you; this tactic is known as "teach back" and helps providers determine if patients understood what they were told. Lastly, throughout this process, demonstrate respect and sensitivity towards patients, which empowers them to participate in their own healthcare.

The County of San Diego, Health and Human Services Agency is working through community coalitions and partnerships, such as the Reduce and Eliminate Health Disparities Initiative (REHDI), to increase awareness about the importance of health literacy. In addition, the Agency is devising efforts to address the issue within County public health facilities. Specifically, emphasis is being placed on generating reading materials at a fifth-grade reading level or lower, as well as improving communication between providers and patients. The Agency's health disparity task force is reviewing current practices for developing written materials and meeting language interpretation needs. The task force will eventually make recommendations for the development of written materials and the provision of translation services in the public health facilities.

References: ■ **1.** A Selection of Health Literacy Articles and Research, Partnership for Clear Health Communication. www.phfch.org. ■ **2.** Health Literacy: A Manual for Clinicians, American Medical Association Foundation and American Medical Association, 2003. ■ **3.** Ad Hoc Committee on Health Literacy for the Council Scientific Affairs, American Medical Association. JAMA 1999;281:552;25. ■ **4.** A Selection of Health Literacy Articles and Research, Center for Health Care Strategies, Fact Sheet #2. www.chcs.org. ■ **5.** Health Literacy: A Prescription to End Confusion, Institute of Medicine of the National Academies, 2004. ■ **6.** Darren A. DeWalt, MD, MPH, Nancy D. Berkman, PhD, Stacey Sheridan, MD, and others. "Literacy and Health Outcomes, A Systematic Review of the Literature. *J Gen Intern Med 2004*; 19:1228-1239. ■ **7.** Richard S. Safeer, M.D. and Jann Keenan, Ed.S. Health Literacy: The Gap Between Physicians and Patients. Amer Fam Physician 2005;72:463–8.

SAN DIEGO COUNTY HEALTH STATS:

HEALTH LITERACY

■ Most healthcare materials are written at a tenth-grade level or higher. However, most adults read between the eighth and ninth grade levels, with 21 to 23 percent of adults reading at the lowest reading level, approximately fifth-grade or lower (1).

■ Patients with inadequate health literacy skills have difficulty controlling chronic illnesses (2), are unable to follow prescription directions (3), and are more likely to be hospitalized (4), which results in an additional $69 billion in healthcare costs annually (5).

To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

References: ■ **1** Kirsch I, Jungeblut A, Jenkins L, Kolstad A. Adult literacy in America: a first look at the findings of the national adult literacy survey. Washington, DC: National Center for Education Statistics, U.S. Department of Education, 1993. Accessed online September 21, 2005, at: http://nces.ed.gov/pubs93/93275.pdf. ■ 2. Williams MV, Baker DW, Parker RM, Nurss JR. Relationship of functional health literacy to patients' knowledge of their chronic disease. A study of patients with hypertension and diabetes. *Arch Intern Med 1998*;158:166–72. ■ 3. Holt GA, Dorcheus L, Hall EL, Beck D, Ellis E, Hough J. Patient interpretation of label instructions. *Am Pharm 1992*;NS32:58–62. ■ 4. Baker DW, Gazmararian JA, Williams MV, Scott T, Parker RM, Green D, et al. Functional health literacy and the risk of hospital admission among Medicare managed care enrollees. *Am J Pub Health 2002*;92:1278–83. ■ 5. Health literacy: a prescription to end confusion. Institute of Medicine, 2004.

Promoting Smoking Cessation:
IN PRIMARY CARE

By Amethyst C. Cureg, MD, MPH, and Tony Vaninetti, MPH

The third Thursday in November is celebrated as the Great American Smokeout. Stopping tobacco use for one day is an important first step to stop smoking. Smoking is the leading cause of morbidity and mortality in the United States. According to the *2004 Surgeon General's Report on the Health Consequences of Smoking*, tobacco use costs the United States approximately $157 billion annually in direct medical care and economic losses (1). During 1988–1997, per capita cigarette smoking in California declined more than twice as rapidly compared with the rest of the country and may, in part, be a result of California tobacco control initiatives (2). California has the second lowest smoking prevalence among adults in the country, at 16 percent, declining 29 percent from 1988. Youth smoking in California is one of the lowest in the nation. Data, from 2004, show that among high school students, smoking rates were 13 percent, compared to 22 percent in 2000, a 39 percent decline (3). While these declines are encouraging, California still has significant improvements to make. In 2004, more than four million Californians still smoked and 38,200 died from their habit (4).

There is evidence that healthcare providers can be effective in promoting smoking cessation. We also know that tobacco use is the most preventable cause of cancer, accounting for 30 percent of all cancer-related deaths in the United States (5). However, only about half of smokers seen by a physician report receiving advice or counseling to quit (6). The World Health Organization and others acknowledge that studies have shown that even brief counseling by a concerned health professional on the dangers of smoking and the importance of quitting is one of the most cost-effective methods of reducing smoking (7). Healthcare providers should take advantage of "teachable moments" and provide advice and counseling to their patients about smoking, especially those with smoking-related health problems. The American Cancer Society, through the Great American Health Checkup, encourages healthcare providers to take the time to ask their patients about their tobacco use as part of a thorough health checkup.

The Clinical Guide to Preventive Services 2005 includes the U.S. Preventive Services Task Force (USPSTF) recommendations that encourage clinicians to screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. The USPSTF also strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke. Their recommended behavioral counseling framework, for engaging patients in smoking cessation discussions, consists of the five As: 1) Asking about tobacco use; 2) Advising to quit through clear, personalized messages; 3) Assessing willingness to quit; 4) Assisting to quit; and 5) Arranging follow-up and support. The USPSTF recommends that counseling include providing problem-solving guidance for smokers to develop a plan to quit and to overcome common barriers to quitting and providing social support within and outside of treatment (8).

The five major steps to intervention, counseling patients to quit, and pharmacotherapy use and prescribing options are all strategies for which there is helpful information and tools, for advising patients on tobacco cessation, available on the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) website (9).

As a well known fact, busy healthcare providers are often hard-pressed to find sufficient time with patients to address health issues and related behavior concerns. A useful adjunct to tobacco-use counseling is use of the telephone "quit-line" (10). In San Diego, clients can call 1-800 NO BUTTS for tailored cessation assistance at no cost. Spanish and other language counselors are on hand. The Tobacco Control Resource Program (TCRP) of the County of San Diego Health and Human Services Agency also has a brochure listing local cessation resources and is available in English and Spanish from the TCRP website at www.sdtcrp.com. Healthcare providers can order cessation materials directly from the California Smokers' Helpline through their website at www.nobutts.org or by calling (858) 300-1010. The Centers for Disease Control and Prevention (CDC) website for Tobacco Information and Prevention Source (TIPS) includes a "How to Quit" link. Visit the CDC website at www.cdc.gov/tobacco.

Additional resources for health professionals include the following websites:

- ***www.ahrq.gov/path/tobacco.htm***
  To directly obtain the Public Health Service Clinical Practice Guideline Treating Tobacco Use and Dependence.
- ***www.medscape.com/viewprogram/3607***
  For a free, online CME activity, Treating Tobacco Use and Dependence, by Michael C. Fiore, MD, MPH.
- ***www.ctri.wisc.edu/main_dept/guide/guide_main.html***
  For training and counseling resources.
- ***www.smokefree.gov***
  This is the national online guide to quitting and a link to local, phone-based quit programs for patient referral.

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The " 5 As" for Brief Smoking Cessation Intervention Framework

Action	Helpful Strategies
1. Ask about tobacco use.	**1.** Screen and document tobacco use at each patient visit.
2. Advise to quit.	**2.** In a clear, strong, and personalized manner, urge every tobacco user to quit.
3. Assess willingness to quit.	**3.** Is tobacco user willing to attempt quitting at this time?
4. Assist in attempt to quit.	**4.** Use counseling and pharmacotherapy to help patients willing to make a quit attempt.
5. Arrange follow up.	**5.** Schedule follow up, preferably within the first week after the quit date.

Sources: ■ Fiore MC, Bailey WC, Cohen SJ, et al. Treating Tobacco Use and Dependence: Clinical Practice Guideline. Washington, DC. US Dept of Health and Human Services: June 2000. Public Health Services Publication no. 000032. ■ Cancer Control 10 (4): 325-333.

References: ■ 1. US Department of Health and Human Services. The health consequences of smoking: A report of the surgeon general - Executive Summary: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; 204. ■ 2. Pierce JP, Gilpin EA, Emery SL, White MM, Rosbrook B, Berry CC. Has the California tobacco control program reduced smoking? JAMA 1998;280:893-9. ■ 3. State of California Department of Health Services Tobacco Control Section. California Student Tobacco Survey, 2002-2004. ■ 4. Special Reports. The Toll of Tobacco in California. Campaign for Tobacco-Free Kids. Available from: http://tobaccofreekids.org/reports/ 2004. ■ 5. American Cancer Society. Cancer Facts & Figures, 2003. Atlanta, Ga: American Cancer Society, Inc; 2003:1-48. ■ 6. Thorndike AN, Rigotti NA, Stafford RS, et al. National patterns in the treatment of smokers by physicians. JAMA. 1998;279:604-608. Abstract. ■ 7. WHO. Health Professionals and Tobacco Control: World No Tobacco Day 2005. ■ 8. USPSTF AHRQ: The Guide to Clinical Preventive Services. Recommendations of the US Preventive Services Task Force, 2005. ■ 9. US Department of Health and Human Services Agency for Health Care Research and Quality Resources. Available from: www.ahrq.gov/clinic/tobacco/5steps.pdf and www.ahrq.gov/path/tobacco.htm. ■ 10. CDC. Strategies for reducing exposure to environmental tobacco smoke, tobacco-use cessation, and reducing initiation in communities and health-care systems. A report on recommendations of the Task Force on Community Preventive Services. MMWR. 2000:49(No.RR-12);1-11.

SAN DIEGO COUNTY HEALTH STATS:

FROM THE CALIFORNIA SMOKERS HELPLINE

July 1, 2004 – June 30, 2005

- The California Smokers Helpline receives, on average, 300 calls a day. From July 2004 to June 2005, the Helpline received 3,285 calls from San Diego County residents (1).

- The average caller to the Helpline is usually between the ages of 25 and 44, Caucasian, and female. The group aged 45–64 years had the second most calls. Seventy-seven percent of callers, for this period, were between the ages of 25 and 64 (1).

November is the Great American Smokeout. For more information about the Great American Smokeout, go to their website at www.cancer.org. To request additional health statistics describing health behaviors, diseases, and injuries for specific populations, health trends, and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 515-4318. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

References: ■ 1. University of California San Diego, Family & Preventive Medicine, Callers to California Smokers' Helpline from San Diego County (July 1, 2004–June 30, 2005), July 11, 2005. Requested data.

Handwashing:

AN IMPORTANT TOOL IN THE FIGHT AGAINST COLDS, FLU, AND OTHER CONTAGIOUS

By Harrison Bolter

Given the increased concern about influenza, and especially avian influenza and the prospects of an influenza pandemic, it seems an auspicious time to highlight an important tool in the fight against colds, influenza, and other contagious diseases: handwashing.

National Handwashing Awareness Week (December 4–10, 2005) is an observance designed to draw attention to the importance of handwashing in promoting health and preventing disease. The simple act of washing one's hands thoroughly, with plenty of soap and warm water, when practiced regularly, can help reduce the spread of contagious diseases like influenza and colds. In concert with other good health practices — such as getting enough sleep, exercising regularly, and eating a healthy, balanced diet — handwashing can play a valuable role in maintaining overall good health.

Perhaps because handwashing is so simple, it is taken for granted, and probably not practiced nearly as widely as it should be. In an August 2005 survey sponsored by the American Society for Microbiology and the Soap and Detergent Association, 91 percent of adults said they always wash their hands after using public restrooms; however, just 83 percent were observed doing so. Americans who said they "always wash their hands" after using the bathroom in their home (83 percent) and before handling or eating foods (77 percent) was reported. However, smaller percentages of Americans always wash after petting a dog or cat (42 percent), after coughing or sneezing (32 percent), or after handling money (21 percent) (1). According to the Centers for Disease Control and Prevention (CDC), some viruses and bacteria can live from 20 minutes up to 2 hours or more on surfaces like cafeteria tables, doorknobs, and desks (2).

It seems likely that poor handwashing can contribute to the spread of influenza and colds. CDC estimates that 5–20 percent of Americans come down with the flu during each flu season, which typically lasts from November to March. Although most people recover from flu, CDC estimates that in the United States more than 200,000 people are hospitalized and about 36,000 people die from the flu and its complications each year (3). According to CDC, nearly 22 million school days are lost due to the common cold alone (4).

However, handwashing is most effective at reducing the chances of getting and spreading disease if it is done properly and often. Proper handwashing consists of washing the hands (including wrists, palms, backs of hands, fingers, and under fingernails) for 20 seconds, using soap and warm water (5). Hands should be dried with a paper towel. Use the paper towel to turn off the water to avoid contaminating the hands and then spreading those germs. The paper towel should be thrown in a wastebasket when finished. This procedure should be followed after using the restroom, before eating, and anytime the hands get dirty.

Children should be taught not to sneeze or cough into their bare hands but to use a tissue (or their sleeve) whenever possible and to avoid putting their fingers into their eyes, nose, or mouth. Adults, too, should be advised to follow these practices to reduce the spread of germs that can cause colds and flu.

Lastly, hand hygiene is not only important for the general public but is recognized as the leading measure to prevent cross-transmission of microorganisms and to reduce the incidence of healthcare-associated infections (6, 7). However, research finds that this group falls short of optimal behavior. In a 2004 article in the *Annals of Internal Medicine*, physicians' adherence to hand hygiene was low in most hospitals (8). This observational study of 163 physicians in a university hospital found that overall adherence to hand hygiene guidelines was only 57 percent and varied markedly across medical specialties. In this study adherence was associated with the awareness of being observed, the belief of being a role model for other colleagues, and a positive attitude about hand hygiene after patient contact. Alternatively, high workload, performing activities with high risks for cross-transmission, and certain medical specialties (surgery, anesthesiology, emergency medicine, and intensive care medicine) were risk factors for non-adherence. Development of a positive attitude about hand hygiene by healthcare staff is instrumental in transference of these behaviors to patients in an effort to safeguard against transmission of diseases such as the flu or colds.

Therefore, healthcare staff is encouraged to practice good hand hygiene between patients and to promote this behavior by patients to help prevent the spread of disease. For more information on this subject, please visit the CDC's Infection Control in Health Care Facilities website at: www.cdc.gov/flu/professionals/infectioncontrol/index.htm.

Physicians and other healthcare staff are encouraged to share general advice about hand hygiene information with patients. Following these simple steps will greatly contribute to the protection of patients' health:

About the Author: *Harrison Bolter is the health information specialist for the County of San Diego Health and Human Services Agency's Immunization Branch. He has held this position for the past nine years and is involved in the production of educational materials for the Branch.*

DISEASES

1. Wash hands often with soap and warm water;
2. Avoid touching eyes, nose, or mouth as much as possible;
3. Stay away from people who are sick;
4. Cover the mouth and nose with a tissue or sleeve when coughing or sneezing; and
5. Get regular exercise, enough rest, and eat healthy, balanced meals.

These habits can help protect individuals and their family, friends, co-workers, casual contacts, and others from diseases like the flu and colds all year long.

While behavioral change is seldom easy, getting into the habit of proper handwashing, practiced often, can result in reduced incidence of disease and enhancing overall good health. Isn't this well worth the time and effort required? ❁

References: American Society for Microbiology website, (www.washup.org/index.html). ■ CDC website, Preventing the Flu, Fast Facts, June 13, 2005, (www.cdc.gov/flu/school/). ■ CDC Fact Sheet, Key Facts about Influenza and the Influenza Vaccine, Sept. 28, 2005, (www.cdc.gov/flu/keyfacts.htm). ■ CDC website, Preventing The Flu, Fast Facts, June 13, 2005, (www.cdc.gov/flu/school/). ■ CDC website, Stopping Germs at Home, Work and School, February 1, 2004, (www.cdc.gov/germstopper/home_work_school.htm). ■ Pittet D, Hugonnet S, Harbarth S, Mourouga P, Sauvan V, Touveneau S, et at. Effectiveness of a hospital-wide programme to improve compliance with hand hygiene. Infection Control Programme. Lancet. 2000;356:1307-12. ■ Boyce JM, Pittet D. Guidelines for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Society for Healthcare Epidemiology of America/Association for Professionals in Infection Control/Infectious Diseases Society of American. MMWR Recomm Rep. 2002;51:1-45. ■ Pittet D, Simon A, Hugonnet S, et al. Hand Hygiene Among Physicians: Performance, Beliefs, and Perceptions. Annals of Internal Medicine. 2004;131:1-8. (www.annals.org/cgi/content/abstract/141/1/1).

This article contains important information about proper hand hygiene (or handwashing) and its role in reducing the spread of diseases like influenza and colds. We encourage you to share these messages with your patients.

THANK YOU.

SAN DIEGO COUNTY HEALTH STATS

INFLUENZA

- As part of the CDC's influenza surveillance program, about 80 World Health Organization (WHO) and 50 National Respiratory and Enteric Virus Surveillance System (REVSS) collaborating laboratories located throughout the United States report the total number of respiratory specimens tested and the number positive for influenza types A and B each week (1).

- A study conducted in 2004 by the CDC concluded that the rates of influenza-associated hospitalization during an influenza season are highest when influenza A (H3N2) viruses predominate compared to years when influenza A (H1N1) or influenza B viruses predominated (2).

To request additional health statistics describing health behaviors, diseases and injuries for specific populations, health trends and comparisons to national targets, please call the County's Community Health Statistics Unit at (619) 285-6479. To access the latest data and data links, including the 2004 Core Public Health Indicator document, go to www.sdhealthstatistics.com.

References: ■ 1. CDC website, Influenza Summary Update, Week ending October 8, 2005 — Week 40, www.cdc.gov/flu/weekly/. ■ 2. CDC website, Flu Home, Questions & Answers: Influenza-associated Hospitalizations in the United States, September 22, 2004. www.cdc.gov/flu/about/qa/hospital.htm.

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the outcome of these efforts to assure that DEA numbers and the NPI are only available and used for their intended purposes; and (4) undertake a widespread campaign to inform physicians that the use of DEA numbers for purposes of identification other than for prescription of controlled substances is inappropriate and that this campaign be positioned to inform the various entities which inappropriately request DEA numbers. (Res. 905)

19. Status Report on Expanding Healthcare Coverage to All Individuals, With An Emphasis on the Uninsured: Adopted as a amended recommendations of Council on Medical Service Report 1, with the remainder of the report filed. The report recommends that AMA: (1) continue to place a high priority on expanding health insurance coverage for all; (2) continue to pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; (3) continue to explore and support alternative means of ensuring healthcare coverage for all; and (4) that the AMA Board of Trustees consider assisting Louisiana and other Gulf coast states if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region. (CMS Report 1)

20. Health Insurance Coverage of Specialty Pharmaceuticals: Adopted as a amended recommendations of Council on Medical Service Report 2, with the remainder of the report filed. The report recommends that AMA: (1) reaffirm Policy H-125.991[5], which "encourages mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third-party payers not to excessively shift costs to patients so they cannot afford necessary drug therapies;" (2) support complete transparency of healthcare coverage policies related to specialty pharmaceuticals, including co-payment or co-insurance levels and how these levels are determined; (3) adopt policy that employers and health insurers should eliminate the lifetime maximums of health insurance benefits; and (4) AMA continue to monitor health plan treatment of specialty pharmaceuticals to ensure patient access to needed pharmaceuticals, and report back to the House of Delegates at the 2006 Interim Meeting. (CMS Report 2) ❁